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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10929 CERTIFICATE OF DEATH

10932  
Reg. Dist. No. 202

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Kent</u>		STATE <u>Penna</u>		COUNTY <u>Lancaster</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chestertown</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lancaster</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>near- Fairlee</u>		STREET ADDRESS <u>2759 Lititz Pike</u>		(If rural give location)		<u>75X-3</u> ✓	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Ivan R. Adams</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Nov. 21, 1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 12, 1896</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Prod. Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Milk Dairy</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John R. Adams</u>				14. MOTHER'S MAIDEN NAME <u>Marion Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u>		16. SOCIAL SECURITY NO. <u>I70-09-0680</u>		17. INFORMANT & ADDRESS <u>Lancaster, Pa. 2759 Lititz Pike</u> <u>Mrs. Ivan R. Adams</u>			
<b>18. MEDICAL CERTIFICATION</b>						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> IMMEDIATE CAUSE (A) <u>Probable Coronary Thrombosis</u>						<u>a few minuts</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) _____ (C) _____							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 21, 1955</u> , to <u>Nov. 21, 1955</u> , that I last saw the deceased alive on <u>Nov. 21, 1955</u> , and that death occurred at <u>11:00 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Robert W. Farr</u>		M.D. <u>Chestertown, Md.</u>		ADDRESS (Street, city, town, state) <u>Nov. 22, 1955</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/26/55</u>		NAME OF CEMETERY OR CREMATORY <u>Moscow Cem.</u>		LOCATION (City, town, or county) (State) <u>Moscow, Penna.</u>	
24. REC'D BY REGISTRAR DATE <u>Nov. 23-55</u>		REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>		ADDRESS <u>Chestertown, Maryland</u>	

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## 10930 CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Kent Co.</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		17X-2	
37 TOWN <u>Chestertown</u>		3 weeks		Rural <u>Chestertown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
72 <u>Kent &amp; Queen Anne Hospital</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>REBECCA R ANTHONY</u>				<u>March 26 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>W</u>	<u>WIDOWED</u>	<u>JUNE 25 1888</u>	<u>67</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSEWIFE</u>		<u>HOMIE</u>		<u>N.J. New Jersey</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Joseph Riegley</u>				<u>Rebecca Miller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>1970</u>		<u>None</u>		<u>Kent &amp; Queen Anne Hosp. Records</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
<u>420.1</u>				<u>3 weeks</u>			
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Thrombophlebitis (left leg)</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/7</u> , 19 <u>53</u> to <u>11/26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/26</u> , 19 <u>55</u> , and that death occurred at <u>2:50</u> M, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>W. L. Man</u>				<u>11/27/55</u>			
M. D.				ADDRESS			
<u>Chestertown, Md</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>Nov 28, 1955</u>		<u>Chesler Cemetery</u>		<u>Chestertown Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Nov. 28-1955</u>		<u>Clara L. Barnes</u>		<u>Barton Bros. Antietam, Maryland</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 30 1955

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10936 **CERTIFICATE OF DEATH**

10934

Reg. Dist. No. 201

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>KENT</u>		STATE <u>MD.</u> COUNTY <u>KENT</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>STILL POND</u>		LENGTH OF STAY (In this place) <u>35 YRS</u>		CITY OR TOWN <u>STILL POND</u>		CITY OR TOWN <u>STILL POND</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>				STREET ADDRESS (If rural give location) <u>—</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>BENJAMIN R. FELLOWS</u>				<u>NOV. 24 1955</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWER</u>	8. DATE OF BIRTH <u>JUNE 20, 1881</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FUN'L DIR.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FUNERAL</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS FELLOWS</u>				14. MOTHER'S MAIDEN NAME <u>ELIZA WARD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>LUCILE KENNEDY STILL POND, MD.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
201X IMMEDIATE CAUSE (A) <u>Hodgkins disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>16 months</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-28</u> , 19 <u>55</u> , to <u>11-24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11-23</u> , 19 <u>55</u> , and that death occurred at <u>5:25</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M.D. <u>Chester Town, Md.</u>		DATE SIGNED <u>11-24-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>NOV. 27, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>STILL POND CEMETERY</u>		LOCATION (City, town, or county) <u>STILL POND, MD.</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>Victor N. Kennedy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>STILL POND, MD.</u>		ADDRESS <u>—</u>	
DATE <u>11/25/55</u>							





**INSTRUCTIONS**

**1**

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**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10931 **CERTIFICATE OF DEATH**

10935

Reg. Dist. No. 202

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>KENT</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>CHESTERTOWN</u>		<u>10 days</u>		TOWN <u>CRUMPTON</u>		<u>17X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kent + Queen Annes</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>MYRTLE</u> (Middle) <u>HARTLEY</u> (Last) <u>GALE</u>				(Month) <u>NOV</u> (Day) <u>8</u> (Year) <u>1955</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>F</u>	<u>W</u>	<u>MARRIED</u>	<u>JUN 18, 1890</u>	<u>65</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Housewife</u>				<u>MARYLAND</u>		<u>USA.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Benjamin Hartley</u>				<u>Lee Cruser</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>3 No</u>		<u>219-10-9706</u>		<u>Lloyd Gale, Millington, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>584X IMMEDIATE CAUSE</b> (A) <u>Abscess of Pancreas</u>						<u>3 Weeks</u>	
<b>ANTECEDENT CAUSE(S)</b> DUE TO (B) <u>Chronic Cholecystitis + Cholelithiasis</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> DUE TO (C) <u>CAUSE LAST</u>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>10-28-55</u>		<u>Gall-Stones; Abscess of Pancreas</u>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)			<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>		
<b>22. I hereby certify that I attended the deceased from <u>Oct 27, 1955</u>, to <u>Nov 8, 1955</u>, that I last saw the deceased alive on <u>Nov 7, 1955</u>, and that death occurred at <u>2:20 A.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>G. J. Keefe, Jr.</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>CHESTERTOWN, Md.</u>		<b>DATE SIGNED</b> <u>11-8-55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>Nov. 11</u>		<u>Crumpton</u>		<u>Crumpton Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>Nov. 10-1955</u>		<u>Clara L. Barnes</u>		<u>Edgar L. Kane</u>		<u>Church Hill Md.</u>	

1935

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

# 1935 - CERTIFICATE OF DEATH

1. NAME OF DECEASED (Print or Write)

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. SIGNATURE OF PHYSICIAN

BUREAU V. 2

NOV 14 1935

RECEIVED

RECORDS SECTION



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10937 CERTIFICATE OF DEATH

10936

Reg. Dist. No. 201

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>KENT</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>KENT</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>LYNCH</u>		<u>LIFE</u>		TOWN <u>LYNCH</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>VIRGINIA</u> (Middle) <u>A.</u> (Last) <u>GEORGE</u>				(Month) <u>NOV.</u> (Day) <u>7</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>OCT. 24, 1922</u>	<u>33</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>SECRETARY</u>		<u>LAW OFFICE</u>		<u>MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>JAMES L. ARCHIBALD SR.</u>				<u>SADIE KNIGHT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>215-14-3560</u>		<u>LINWOOD GEORGE LYNCH, MD.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
465X IMMEDIATE CAUSE (A) <u>Pulmonary Thrombosis</u>							
ANTECEDENT CAUSE(S) DUE TO <u>none</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 7, 1955</u> , to <u>Nov 7, 1955</u> , that I last saw the deceased alive on <u>Nov 7, 1955</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>L. P. Atwood</u>				DATE SIGNED <u>11/8/55</u>			
				ADDRESS (Street, city, town, state) <u>Still Pond</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>11-10-55</u>		<u>CHESTER CEMETERY</u>		<u>CHESTERTOWN, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>11/8/55</u>		<u>E. Keenard Jones</u>		<u>B.R. Fellows</u>		<u>STILL POND, MD.</u>	

100321

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

# 100321 CERTIFICATE OF DEATH

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10937

## 10932 CERTIFICATE OF DEATH

Reg. Dist. No. 202

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Queen Anne</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Chester Town</u>		<u>Two days</u>		TOWN <u>Pondtown</u>		<u>17X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kent and Queen Anne's Hospital</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Lacy</u>				<u>Griffin</u>			
<b>5. SEX</b>		<b>6. COLOR OR RACE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify)		<b>8. DATE OF BIRTH</b>	
<u>F</u>		<u>C</u>		<u>Widowed</u>		<u>6-27-1896</u>	
						<b>9. AGE last birthday</b>	
						<u>39</u> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)	
<u>Retired School Teacher</u>						<u>Parkley - Va</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Handy Parks</u>				<u>Rosie Genter</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>	
<u>No</u>				<u>None</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>33IX</b> IMMEDIATE CAUSE (A)						<u>Coronary Vascular Accidents</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						<u>Hypertension</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>						<u>Digitalis Toxicity.</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, of injury street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>11/17, 1955</u> , to <u>11/18, 1955</u> , that I last saw the deceased alive on <u>11/18, 1955</u> , and that death occurred at <u>11:45 A.M.</u> , from the causes and on the date stated above.							
<b>SIGNATURE</b>		<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>			
<u>Thomas J. Solow</u>		<u>Washington Ave. Chestertown</u>		<u>11/19/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION</b> (City, town, or county) (State)	
<u>Burial</u>		<u>11-21-55</u>		<u>Pondtown</u>		<u>Queen Anne Co. Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<u>Nov. 22-55</u>		<u>Clara S. Barnes</u>		<u>James H. Bates, Jr. Centerville, Maryland</u>			

RECEIVED

THIS CERTIFICATE OF DEATH IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON WHO HAS BEEN IN ATTENDANCE ON THE DECEASED AT THE TIME OF HIS OR HER DEATH. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, CITY AND COUNTY OF BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE FAMILY OF THE DECEASED. IT IS TO BE FURNISHED TO THE FAMILY OF THE DECEASED.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

DATE OF BIRTH

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BUREAU V. S.

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10933 CERTIFICATE OF DEATH

10938

Reg. Dist. No. 202

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
37 TOWN <u>Chestertown</u>		<u>Life</u>		37 TOWN <u>Chestertown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)					
72 <u>Kent &amp; Queen Anne Hospital</u>				<u>I02 Prospect St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>James</u> (Middle) <u>H.</u> (Last) <u>Hamilton</u>				(Month) <u>Nov.</u> (Day) <u>24</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>male</u>	<u>colored</u>	<u>widowed</u>	<u>Dec. 6, 1882</u>	<u>72</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer</u>		<u>various</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>General Hamilton</u>				<u>Elizabeth Granger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>717-07-9131</u>		<u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
572.2 IMMEDIATE CAUSE (A) <u>G.I. Bleeding</u> Active -				INTERVAL BETWEEN ONSET AND DEATH <u>10 DAY</u>			
ANTECEDENT CAUSE(S) DUE TO <u>Ulcerative colitis</u>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Depression</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Possible Ew. - 2.</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/20</u> , 19 <u>55</u> , to <u>11/24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/24</u> , 19 <u>55</u> , and that death occurred at <u>9 P</u> M, from the causes and on the date stated above.							
SIGNATURE		Thomas Solon M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Thomas Solon</u>		<u>Chestertown, Md.</u>		<u>II/24/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>II/27/55</u>		<u>Janes (col.) Cem.</u>		<u>Chestertown, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Nov. 25-1955</u>		<u>Clara L. Barnes</u>		<u>Willis Wells</u>		<u>Chestertown Maryland</u>	



CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF PHYSICIAN	
10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF CORONER	
13. SIGNATURE OF JURY		14. SIGNATURE OF JUDGE		15. SIGNATURE OF CLERK	
16. SIGNATURE OF SHERIFF		17. SIGNATURE OF DEPUTY SHERIFF		18. SIGNATURE OF CONSTABLE	
19. SIGNATURE OF TOWNSHIP CLERK		20. SIGNATURE OF COUNTY CLERK		21. SIGNATURE OF STATE CLERK	
22. SIGNATURE OF FEDERAL CLERK		23. SIGNATURE OF MARSHAL		24. SIGNATURE OF DEPUTY MARSHAL	
25. SIGNATURE OF JAILER		26. SIGNATURE OF DEPUTY JAILER		27. SIGNATURE OF WARDEN	
28. SIGNATURE OF DEPUTY WARDEN		29. SIGNATURE OF CHIEF OF POLICE		30. SIGNATURE OF DEPUTY CHIEF OF POLICE	
31. SIGNATURE OF SHERIFF		32. SIGNATURE OF DEPUTY SHERIFF		33. SIGNATURE OF CONSTABLE	
34. SIGNATURE OF TOWNSHIP CLERK		35. SIGNATURE OF COUNTY CLERK		36. SIGNATURE OF STATE CLERK	
37. SIGNATURE OF FEDERAL CLERK		38. SIGNATURE OF MARSHAL		39. SIGNATURE OF DEPUTY MARSHAL	
40. SIGNATURE OF JAILER		41. SIGNATURE OF DEPUTY JAILER		42. SIGNATURE OF WARDEN	
43. SIGNATURE OF DEPUTY WARDEN		44. SIGNATURE OF CHIEF OF POLICE		45. SIGNATURE OF DEPUTY CHIEF OF POLICE	
46. SIGNATURE OF SHERIFF		47. SIGNATURE OF DEPUTY SHERIFF		48. SIGNATURE OF CONSTABLE	
49. SIGNATURE OF TOWNSHIP CLERK		50. SIGNATURE OF COUNTY CLERK		51. SIGNATURE OF STATE CLERK	
52. SIGNATURE OF FEDERAL CLERK		53. SIGNATURE OF MARSHAL		54. SIGNATURE OF DEPUTY MARSHAL	
55. SIGNATURE OF JAILER		56. SIGNATURE OF DEPUTY JAILER		57. SIGNATURE OF WARDEN	
58. SIGNATURE OF DEPUTY WARDEN		59. SIGNATURE OF CHIEF OF POLICE		60. SIGNATURE OF DEPUTY CHIEF OF POLICE	
61. SIGNATURE OF SHERIFF		62. SIGNATURE OF DEPUTY SHERIFF		63. SIGNATURE OF CONSTABLE	
64. SIGNATURE OF TOWNSHIP CLERK		65. SIGNATURE OF COUNTY CLERK		66. SIGNATURE OF STATE CLERK	
67. SIGNATURE OF FEDERAL CLERK		68. SIGNATURE OF MARSHAL		69. SIGNATURE OF DEPUTY MARSHAL	
70. SIGNATURE OF JAILER		71. SIGNATURE OF DEPUTY JAILER		72. SIGNATURE OF WARDEN	
73. SIGNATURE OF DEPUTY WARDEN		74. SIGNATURE OF CHIEF OF POLICE		75. SIGNATURE OF DEPUTY CHIEF OF POLICE	
76. SIGNATURE OF SHERIFF		77. SIGNATURE OF DEPUTY SHERIFF		78. SIGNATURE OF CONSTABLE	
79. SIGNATURE OF TOWNSHIP CLERK		80. SIGNATURE OF COUNTY CLERK		81. SIGNATURE OF STATE CLERK	
82. SIGNATURE OF FEDERAL CLERK		83. SIGNATURE OF MARSHAL		84. SIGNATURE OF DEPUTY MARSHAL	
85. SIGNATURE OF JAILER		86. SIGNATURE OF DEPUTY JAILER		87. SIGNATURE OF WARDEN	
88. SIGNATURE OF DEPUTY WARDEN		89. SIGNATURE OF CHIEF OF POLICE		90. SIGNATURE OF DEPUTY CHIEF OF POLICE	
91. SIGNATURE OF SHERIFF		92. SIGNATURE OF DEPUTY SHERIFF		93. SIGNATURE OF CONSTABLE	
94. SIGNATURE OF TOWNSHIP CLERK		95. SIGNATURE OF COUNTY CLERK		96. SIGNATURE OF STATE CLERK	
97. SIGNATURE OF FEDERAL CLERK		98. SIGNATURE OF MARSHAL		99. SIGNATURE OF DEPUTY MARSHAL	
100. SIGNATURE OF JAILER		101. SIGNATURE OF DEPUTY JAILER		102. SIGNATURE OF WARDEN	

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10938

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10939

Reg. Dist.

No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Kent</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Galena</u>		<u>Entire life</u>		TOWN <u>Galena</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>at home</u>				STREET ADDRESS (If rural, give location) <u>11</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>ELMER SINCLAIR JARMAN</u>				<u>December 11 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>June 16, 1873</u>	<u>82</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Farming</u>		<u>Farm</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John Wesley Jarmann</u>				<u>Agnes Carey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>?</u>		<u>Mrs. James Ryan - Galena, Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause		(a) <u>Sore Burn (probable.)</u>				<u>15 min.</u>	
Antecedent cause(s)		(b) <u>(possible carbon monoxide poisoning)</u>				<u>15 min.</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		DUE TO <u>was an aged invalid. Death may have occurred prior to fire. This will depend on finding CO in blood.</u>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>Many years</u>	
19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:						20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) (County) (State)			
<u>probably</u>		<u>home</u>		<u>Galena Kent Md.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Room was forced open. Had not clothing on fire started from</u>			
<u>11 11 55 30 P.M.</u>				<u>operation</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED	
<u>Robert W. Farr</u>						<u>11/11/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov. 13 1955</u>		<u>Galena Cemetery</u>		<u>Galena Kent Co. Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Nov. 12, 1955</u>		<u>Elizabeth J. Mulford</u>		<u>Marion V. Williams - Chestertown, Md.</u>			

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 15 1951

RECEIVED

60  
-1-16  
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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10940

## 10939 CERTIFICATE OF DEATH

Reg. Dist. No. 201

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>KENT</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>KENT</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>STILL POND</u>		<u>LIFE</u>		TOWN <u>STILL POND</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
100				1			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>WILLIAM</u> (Middle) <u>ELIGH</u> (Last) <u>MILLIGAN</u>				NOV. 23 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	COLORED	WIDOWER	FEB 15, 1878	77 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
LABORER		FARM		MARYLAND		U.S.A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
GEORGE MILLIGAN				MARTHA FORD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		220-03-2038		ANNA JOHNSON STILL POND MD.			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
454X IMMEDIATE CAUSE (A)						Interval BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
		Home					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 20, 1955, to Mar 23, 1955, that I last saw the deceased alive on Mar 23, 1955, and that death occurred at 12:25 P.M. from the causes and on the date stated above.							
SIGNATURE <u>L. P. Alwell</u>				DATE SIGNED <u>Mar 23, 1955</u>			
M.D. <u>Still Pond</u>				Address (Street, city, town, state) <u>2nd 11-24-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		NOV. 26, 1955		MT. ZION CEMETERY		STILL POND MD.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>11/27/55</u>		<u>E. K. Howard Jones</u>		<u>Victor N. Kennedy</u>		STILL POND, MD.	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

<p>NAME: <b>WILLIAM ELIAS WILLIAMS</b></p> <p>DATE OF BIRTH: <b>17 FEB 1878</b></p> <p>PLACE OF BIRTH: <b>WYOMING</b></p> <p>DATE OF DEATH: <b>28 NOV 1955</b></p> <p>PLACE OF DEATH: <b>STILL POINT</b></p>	<p>NAME: <b>GEORGE WILLIAM</b></p> <p>DATE OF BIRTH: <b>17 FEB 1878</b></p> <p>PLACE OF BIRTH: <b>WYOMING</b></p> <p>DATE OF DEATH: <b>28 NOV 1955</b></p> <p>PLACE OF DEATH: <b>STILL POINT</b></p>
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<p>NAME: <b>WILLIAM ELIAS WILLIAMS</b></p> <p>DATE OF BIRTH: <b>17 FEB 1878</b></p> <p>PLACE OF BIRTH: <b>WYOMING</b></p> <p>DATE OF DEATH: <b>28 NOV 1955</b></p> <p>PLACE OF DEATH: <b>STILL POINT</b></p>	<p>NAME: <b>GEORGE WILLIAM</b></p> <p>DATE OF BIRTH: <b>17 FEB 1878</b></p> <p>PLACE OF BIRTH: <b>WYOMING</b></p> <p>DATE OF DEATH: <b>28 NOV 1955</b></p> <p>PLACE OF DEATH: <b>STILL POINT</b></p>
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<p>NAME: <b>WILLIAM ELIAS WILLIAMS</b></p> <p>DATE OF BIRTH: <b>17 FEB 1878</b></p> <p>PLACE OF BIRTH: <b>WYOMING</b></p> <p>DATE OF DEATH: <b>28 NOV 1955</b></p> <p>PLACE OF DEATH: <b>STILL POINT</b></p>	<p>NAME: <b>GEORGE WILLIAM</b></p> <p>DATE OF BIRTH: <b>17 FEB 1878</b></p> <p>PLACE OF BIRTH: <b>WYOMING</b></p> <p>DATE OF DEATH: <b>28 NOV 1955</b></p> <p>PLACE OF DEATH: <b>STILL POINT</b></p>
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**RECEIVED**  
 NOV 28 1955  
 BUREAU V. S.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10940

## CERTIFICATE OF DEATH

10941

Reg. Dist. No. 203

Item 8, Film G189 12-5-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Kent</u>		STATE <u>Maryland</u> COUNTY <u>Kent</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>	
CITY OR TOWN <u>Rock Hall</u>		LENGTH OF STAY (in this place) <u>life</u>		STREET ADDRESS <u>Edsville</u>		STREET ADDRESS (If rural give location) <u>Edsville</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>GEORGE A. SCOTT</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 24 19 55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>May, 30, 1877</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>		11. BIRTHPLACE (State or foreign country) <u>Rock Hall, Kent Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Scott</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>George T. Scott-Rock Hall, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>several months</u>			
151X IMMEDIATE CAUSE (A) <u>Carcinoma of stomach</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept</u> 19 <u>55</u> , to <u>Nov 24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov 24</u> , 19 <u>55</u> , and that death occurred at <u>4</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Willard F. Smith</u>		M.D. <u>Rock Hall</u>		ADDRESS (Street, city, town, state) <u>Rock Hall</u>		DATE SIGNED <u>11/28/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 28, /55</u>		NAME OF CEMETERY OR CREMATORY <u>Sharptown Cemetery</u>		LOCATION (City, town, or county) <u>Rock Hall, Md.</u>	
24. REC'D BY REGISTRAR <u>Mr 27 / 53</u>		REGISTRAR'S SIGNATURE <u>W. Elwood Burgess</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams</u>		ADDRESS <u>Chestertown, Md</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

Form No. 10

1. NAME OF DECEASED

MARYLAND

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF BURIAL PLACE

15. SIGNATURE OF INTERVIEWER

16. SIGNATURE OF INTERVIEWER

17. SIGNATURE OF INTERVIEWER

18. SIGNATURE OF INTERVIEWER

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF INTERVIEWER

INVESTIGATION

AT WASHINGTON

TO BUREAU OF HEALTH

BY WASHINGTON

BUREAU V. S.

DEC 1 1955

RECEIVED



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10934

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10942  
Reg. Dist.

No. 202

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Kent	MARYLAND	STATE Maryland	COUNTY Kent
CITY (If outside corporate limits, write RURAL OR and give nearest town) 37 TOWN Chestertown		CITY (If outside corporate limits write RURAL and give nearest town) TOWN Chestertown 37	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cannon St. Extended		STREET ADDRESS (If rural, give location) 1	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) Rulgy	(Middle) L. Taylor	(Month) Nov.	(Day) 24 (Year) 19 55
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 2/25/ 1902
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Laborer (Various) farm		9. AGE last birthday: 53 yrs.	11. BIRTHPLACE (State or foreign country): Maryland
13. FATHER'S NAME: Elwood Taylor		14. MOTHER'S MAIDEN NAME: Josephine Rulgy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY No.: 212-12-1434	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: Mrs. Rulgy Taylor Chestertown Md.	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
231X Immediate cause (a) Probably natural causes		several years	
DUE TO (a) possibly a lung neoplasm			
Antecedent cause(s) (b) Family M. D. tried without success, about a year ago to get Deceased to see a Chest Surgeon.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause DUE TO (c) stating underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		21f. HOW DID INJURY OCCUR?	
SIGNATURE Robert W. Farr,		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11/25/55	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF II/27/55	
NAME OF CEMETERY OR CREMATORY Chester Cemetery		LOCATION (City, town, or county) (State) Chestertown, Md.	
DATE REC'D BY LOCAL REG. 11-25-55		24. FUNERAL DIRECTOR J. Willis Wells - Chestertown, Md.	
REGISTRAR'S SIGNATURE Clara S. Barnes		ADDRESS	

BUREAU V. S.

NOV 28 1955

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10941 CERTIFICATE OF DEATH

10943

Reg. Dist. No. 202

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Kent</u>		STATE <u>Maryland</u> COUNTY <u>Kent</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Chestertown R.D.3</u>		TOWN <u>Chestertown R.D.3</u>		STREET ADDRESS		STREET ADDRESS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Quaker Neck</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Quaker Neck</u>					
<b>3. NAME OF DECEASED</b> (Type or Print) <u>JOSEPH S. TREW Sr.</u>				<b>4. DATE OF DEATH</b> (Month) <u>Nov.</u> (Day) <u>12</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 12, 1869</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>crop</u>		11. BIRTHPLACE (State or foreign country) <u>Quarner Neck, Kent Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Joseph Trew</u>				14. MOTHER'S MAIDEN NAME <u>Anna Rebecca Trew</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Lillie M. Trew-Chestertown, Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b> <u>420.1</u> IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arterio Sclerosis</u>				<b>18. MEDICAL CERTIFICATION</b> <u>Arterio Sclerosis</u> <u>Hypertension</u> <u>Cerebral Thrombosis</u>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 27, 1955</u> , to <u>Nov 12, 1955</u> , that I last saw the deceased alive on <u>Nov 11, 1955</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert C. Hatch</u>				DATE SIGNED <u>Nov 14/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 15, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>		LOCATION (City, town, or county) <u>Chestertown Md</u>	
24. REC'D BY REGISTRAR <u>Nov. 16-1955</u>		REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams</u>		ADDRESS <u>Chestertown, Md.</u>	

# CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. RACE

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. PLACE OF BIRTH

10. OCCUPATION

11. MARITAL STATUS

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEXT OF KIN

17. SIGNATURE OF BURIAL OFFICIAL

18. SIGNATURE OF CHURCH OFFICIAL

19. SIGNATURE OF FUNERAL HOME

20. SIGNATURE OF CEMETERY

BUREAU V. S.

NOV 18 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH  
10935 CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

10944

Reg. Dist. No. 2.02

1. PLACE OF DEATH - COUNTY <b>Kent</b>			2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <b>Maryland</b> COUNTY <b>Kent</b>		
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>			CITY (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Washington Ave</b>			STREET ADDRESS (If rural, give location) <b>Washington Ave.</b>		
3. NAME OF DECEASED (First) <b>Joseph</b> (Middle) <b>N.</b> (Last) <b>Wheatley</b>			4. DATE OF DEATH <b>Nov. 29, 1955</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>single</b>	8. DATE OF BIRTH <b>6/30/ 1891</b>	9. AGE last birthday <b>64</b> yrs.	If under 1 year <b>19</b> Months <b>29</b> Days <b>19</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance agency owner</b>			11. BIRTHPLACE (State or foreign country) <b>Kent Co. Maryland</b>		
13. FATHER'S NAME <b>Joseph N. Wheatley</b>			14. MOTHER'S MAIDEN NAME <b>Frances Russell</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			17. INFORMANT AND ADDRESS <b>Mrs. Annie Culp Washington Ave. Chestertown, Md.</b>		
16. SOCIAL SECURITY NO. <b>don't know</b>			12. CITIZEN OF WHAT COUNTRY <b>USA</b>		

18. MEDICAL CERTIFICATION				
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH
(a) <b>816X Hemopericardium</b>				<b>a few min.</b>
(b) <b>Torn right pulmonary artery --</b>				<b>" " "</b>
(c) <b>Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</b>				
11. OTHER SIGNIFICANT CONDITIONS <b>Complete left pneumothorax and fractured sternum fracture R. and L. ribs 2 thru 7</b>				
19a. DATE OF OPERATION <b>2</b>		19b. MAJOR FINDINGS OF OPERATION <b>contusions of face and upper jaw</b>		20. AUTOPSY? <b>Yes</b> <input checked="" type="checkbox"/> <b>No</b> <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/>		PLACE (Home, farm, factory, street, office bldg., etc.) <b>Route 213</b>	(CITY OR TOWN) <b>Chestertown</b>	(COUNTY) <b>Kent</b> (STATE) <b>Maryland</b>
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>11 29 55 5:15</b>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <b>Drove car into rear of parked truck</b>
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .				
SIGNATURE <b>Robert W. Farr</b>		DATE SIGNED <b>Nov. 30, 1955</b>		
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>Dec. 3, 1955</b>	NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>	LOCATION (City, town, or county) <b>Chestertown, Md.</b> (State)
DATE REC'D BY LOCAL REG. <b>Dec. 2-1955</b>		REGISTRAR'S SIGNATURE <b>Clara S. Barnes</b>	24. FUNERAL DIRECTOR <b>J. Willis Wells</b> ADDRESS <b>Chestertown, Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DEC 5 1955

BUREAU V. S.



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10942 CERTIFICATE OF DEATH

10945

Reg. Dist. No. 200

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>KENT</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>KENT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>MASSEY</u>				TOWN <u>MASSEY</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ERNEST</u> (Middle) <u>H.</u> (Last) <u>WILKINSON</u>				(Month) <u>Nov.</u> (Day) <u>29</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>DEC. 8, 1888</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ASST. SECTY. office BAKING CO.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>WILM. DEL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>WILLIAM WILKINSON</u>				14. MOTHER'S MAIDEN NAME <u>GEORGINA PASTLES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>160-01-0018</u>		17. INFORMANT & ADDRESS <u>MRS. ELSIE G. WILKINSON-MASSEY MD.</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1 IMMEDIATE CAUSE (A) <u>Anterograde Heart Disease</u>						<u>10 years</u>	
2 ANTECEDENT CAUSE(S) DUE TO (B) <u>Mild Stroke</u>						<u>8 days</u>	
3 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 1950</u> , to <u>Nov. 29, 1955</u> , that I last saw the deceased alive on <u>Nov. 28, 1955</u> , and that death occurred at <u>3:30</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Edward Fellows</u>				ADDRESS (Street, city, town, state) <u>Wilmington Md</u>		DATE SIGNED <u>11/29/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>DEC. 3, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>RIVERVIEW CEM.</u>		LOCATION (City, town, or county) <u>WILMINGTON DEL.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Edward Fellows</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u>		ADDRESS <u>Wilmington Md.</u>	
DATE <u>11/29/55</u>							

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1. PLACE OF BIRTH		2. PLACE OF DEATH	
3. SEX		4. RACE	
5. AGE		6. DATE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH	
9. CAUSE OF DEATH		10. MANNER OF DEATH	
11. MEDICAL HISTORY		12. SOCIAL HISTORY	
13. OCCUPATION		14. EDUCATION	
15. RELIGION		16. MARITAL STATUS	
17. FAMILY HISTORY		18. PREVIOUS ILLNESSES	
19. DRUGS		20. ALCOHOL	
21. TOBACCO		22. OTHER	
23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF DEATH REGISTRAR	
25. SIGNATURE OF WITNESSES		26. SIGNATURE OF CORONER	
27. SIGNATURE OF JURY		28. SIGNATURE OF JUDGE	
29. SIGNATURE OF CLERK		30. SIGNATURE OF SHERIFF	
31. SIGNATURE OF DEPUTY SHERIFF		32. SIGNATURE OF CONSTABLE	
33. SIGNATURE OF JAILER		34. SIGNATURE OF PRISON WARDEN	
35. SIGNATURE OF PRISON CHIEF		36. SIGNATURE OF PRISON CLERK	
37. SIGNATURE OF PRISON ATTORNEY		38. SIGNATURE OF PRISON SHERIFF	
39. SIGNATURE OF PRISON DEPUTY SHERIFF		40. SIGNATURE OF PRISON CONSTABLE	
41. SIGNATURE OF PRISON JAILER		42. SIGNATURE OF PRISON WARDEN	
43. SIGNATURE OF PRISON CHIEF		44. SIGNATURE OF PRISON CLERK	
45. SIGNATURE OF PRISON ATTORNEY		46. SIGNATURE OF PRISON SHERIFF	
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51. SIGNATURE OF PRISON CHIEF		52. SIGNATURE OF PRISON CLERK	
53. SIGNATURE OF PRISON ATTORNEY		54. SIGNATURE OF PRISON SHERIFF	
55. SIGNATURE OF PRISON DEPUTY SHERIFF		56. SIGNATURE OF PRISON CONSTABLE	
57. SIGNATURE OF PRISON JAILER		58. SIGNATURE OF PRISON WARDEN	
59. SIGNATURE OF PRISON CHIEF		60. SIGNATURE OF PRISON CLERK	
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67. SIGNATURE OF PRISON CHIEF		68. SIGNATURE OF PRISON CLERK	
69. SIGNATURE OF PRISON ATTORNEY		70. SIGNATURE OF PRISON SHERIFF	
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83. SIGNATURE OF PRISON CHIEF		84. SIGNATURE OF PRISON CLERK	
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87. SIGNATURE OF PRISON DEPUTY SHERIFF		88. SIGNATURE OF PRISON CONSTABLE	
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91. SIGNATURE OF PRISON CHIEF		92. SIGNATURE OF PRISON CLERK	
93. SIGNATURE OF PRISON ATTORNEY		94. SIGNATURE OF PRISON SHERIFF	
95. SIGNATURE OF PRISON DEPUTY SHERIFF		96. SIGNATURE OF PRISON CONSTABLE	
97. SIGNATURE OF PRISON JAILER		98. SIGNATURE OF PRISON WARDEN	
99. SIGNATURE OF PRISON CHIEF		100. SIGNATURE OF PRISON CLERK	

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